# Care Coordination Action Plan

Insert Your Logo Here

**Last Name:** _____ **First Name:** _____ **Date of Birth:** _____

**Date Action Plan Completed:** _____ ☐ **6 Month Review Completed** **Review Date:** _____

**Family Member:** _____ **Phone #:** _____

**HCP Goal:** Family will be confident in coordinating and advocating for their child's health care needs.

| **GOAL #1** *What is it that the family/child wants or needs? Include goal statement and desired outcome.* | | | |
|---|---|---|---|
| **Next Steps:** *List action/ interventions that will help achieve this goal.* | **Person(s) Responsible** | **Target Date** | **Complete Date** |
| a. | | | |
| b. | | | |
| **GOAL #2** *What is it that the family/child wants or needs? Include goal statement and desired outcome.* | | | |
| **Next Steps:** *List action/ interventions that will help achieve this goal.* | **Person(s) Responsible** | **Target Date** | **Complete Date** |
| a. | | | |
| b. | | | |

| **GOAL #3** *What is it that the family/child wants or needs? Include goal statement and desired outcome.* | | | |
|---|---|---|---|
| **Next Steps:** *List action/ interventions that will help achieve this goal.* | **Person(s) Responsible** | **Target Date** | **Complete Date** |
| a. | | | |
| b. | | | |

**Other priority areas that the Family/[child/youth] would like to visit between now and the 6 month review:**

| | |
|---|---|
| 1 | |
| 2 | |
| 3 | |

**I participated in the development of and agree with the above Child/Family Action Plan. _____ Date: _____**
**Copy to: Family / Copy to: _____ Phone #: _____**
**HCP Care Coordinator: _____ Phone #: _____**